

Division of Health Care Facilities

PRINTED: 01/21/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2014
NAME OF PROVIDER OR SUPPLIER HILLVIEW HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on January 21, 2013, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

*Joshua Cannon**Administrator**2-7-14*

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If continuation sheet 1 of 1